Ministerial Council
on Drug Strategy

NATIONAL DRUG STRATEGY 2010–2015

A framework for action on alcohol,
tobacco and other drugs

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Executive summary

The aim of the *National Drug Strategy 2010–2015* is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs are well known. For example, the cost to Australian society of alcohol, tobacco and other drug misuse[1] in the financial year 2004–05 was estimated at $56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime.

The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010–2015. This encompasses the three pillars of:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community
- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs
- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The three pillars apply across all drug types but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention.

In the *National Drug Strategy 2010–2015*, the three pillars are underpinned by strong commitments to:

- building workforce capacity
- evidence-based and evidence-informed practice, innovation and evaluation
- performance measurement
- building partnerships across sectors.

Specific objectives have been identified under each pillar as follows:

Demand reduction

- prevent uptake and delay onset of drug use
- reduce use of drugs in the community
- support people to recover from dependence and reconnect with the community
- support efforts to promote social inclusion and resilient individuals, families and communities.

Supply reduction

- reduce the supply of illegal drugs (both current and emerging)
- control and manage the supply of alcohol, tobacco and other legal drugs.

Harm reduction

- reduce harms to community safety and amenity
- reduce harms to families
- reduce harms to individuals.

Part 1 of the *National Drug Strategy 2010–2015* provides background and explains the conceptual framework of the strategy.

Part 2 details specific objectives and suggested actions under each pillar.

Part 3 discusses the supporting approaches of workforce, evidence, performance monitoring and governance.

1. Collins, D and Lapsley, H 2008, *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*, National Drug Strategy Monograph Series No. 64.

1. About the National Drug Strategy

The National Drug Strategy provides a national framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs.

At the heart of the framework are the three pillars of demand reduction, supply reduction and harm reduction, which are applied together to minimise harm. Prevention is an integral theme across the pillars.

The 2010–2015 framework builds on longstanding partnerships between the health and law enforcement sectors and seeks to engage all levels and parts of government, the non-government sector and the community.

Australia has had a coordinated national policy for addressing alcohol, tobacco and other drugs since 1985 when the National Campaign Against Drug Abuse was developed. In 1993 it was renamed the National Drug Strategy. This 2010–2015 iteration is the sixth time the strategy has been updated to ensure it remains current and relevant to the contemporary Australian environment.

Mission:
To build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

Throughout this strategy, these terms are used:
Drug The term 'drug' includes alcohol, tobacco, illegal (also known as 'illicit') drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour.
Illegal drug A drug that is prohibited from manufacture, sale or possession—for example cannabis, cocaine, heroin and amphetamine type stimulants (ecstasy, methamphetamines).
Pharmaceuticals A drug that is available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse—for example opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids.
Other substances Other psychoactive substances, legal or illegal, potentially used in a harmful way—for example kava, or inhalants such as petrol, paint or glue.

The harms from drug use

The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs is well known.

- The cost to Australian society of alcohol, tobacco and other drug misuse[2] in 2004–05 was estimated at $56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for $31.5 billion (56.2 per cent), alcohol accounted for $15.3 billion (27.3 per cent) and illegal drugs $8.2 billion (14.6 per cent).
- The excessive consumption of alcohol is a major cause of health and social harms. Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and contributes to family breakdown and broader social dysfunction. Drinking during pregnancy can cause birth defects and disability, and there is increasing evidence that early onset of drinking during childhood and the teenage years can interrupt the normal development of the brain.
- Tobacco smoking is one of the top risk factors for chronic disease including many types of cancer, respiratory disease and heart disease.
- Illegal drugs not only have dangerous health impacts but they are a significant contributor to crime. They are a major activity and income source for organised crime groups. Like alcohol, illegal drugs can contribute to road accidents and violent incidents, and to family breakdown and social dysfunction. Unsafe injecting drug use is also a major driver of blood-borne virus infections like hepatitis C and HIV/AIDS.
- Other drugs and substances that are legally available can cause serious harm. The harmful use of inhalants, like petrol, paint and glue, can cause brain damage and death. The misuse of pharmaceutical drugs can have serious health impacts and their trafficking contributes to illegal drug-related crime.
- Alcohol, tobacco and other drug use can contribute to and reinforce social disadvantage experienced by individuals, families and communities. Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, tend to perform more poorly in school and are more likely to be the victims of child maltreatment. Children with parents who drink heavily, smoke or take drugs are more likely to do so themselves—leading to intergenerational patterns of misuse and harms. Family breakdown and job loss is also associated with problematic drug use.
- Disadvantaged populations are at greater risk of harms from alcohol, tobacco and other drug misuse. For example, Aboriginal and Torres Strait Islander peoples experience a disproportionate amount of harms from alcohol, tobacco and other drug use. Drug-related problems play a significant role in disparities in health and life expectancy between Indigenous and non-Indigenous Australians. Indigenous Australians are more likely to die of smoking-related illnesses, such as diseases of the respiratory system and cancers, than other Australians.

Harm minimisation

Since the National Drug Strategy began in 1985, harm minimisation has been its overarching approach. This encompasses the three equally important pillars of demand reduction, supply reduction and harm reduction being applied together in a balanced way.

- **Demand reduction** means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- **Supply reduction** means strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- **Harm reduction** means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

The *National Drug Strategy 2010–2015* seeks to build on this multi-faceted approach which is recognised internationally as playing a critical role in Australia's success in addressing drug use.

2. Collins, D and Lapsley, H 2008, *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*.

Figure 1: Harm minimisation approach

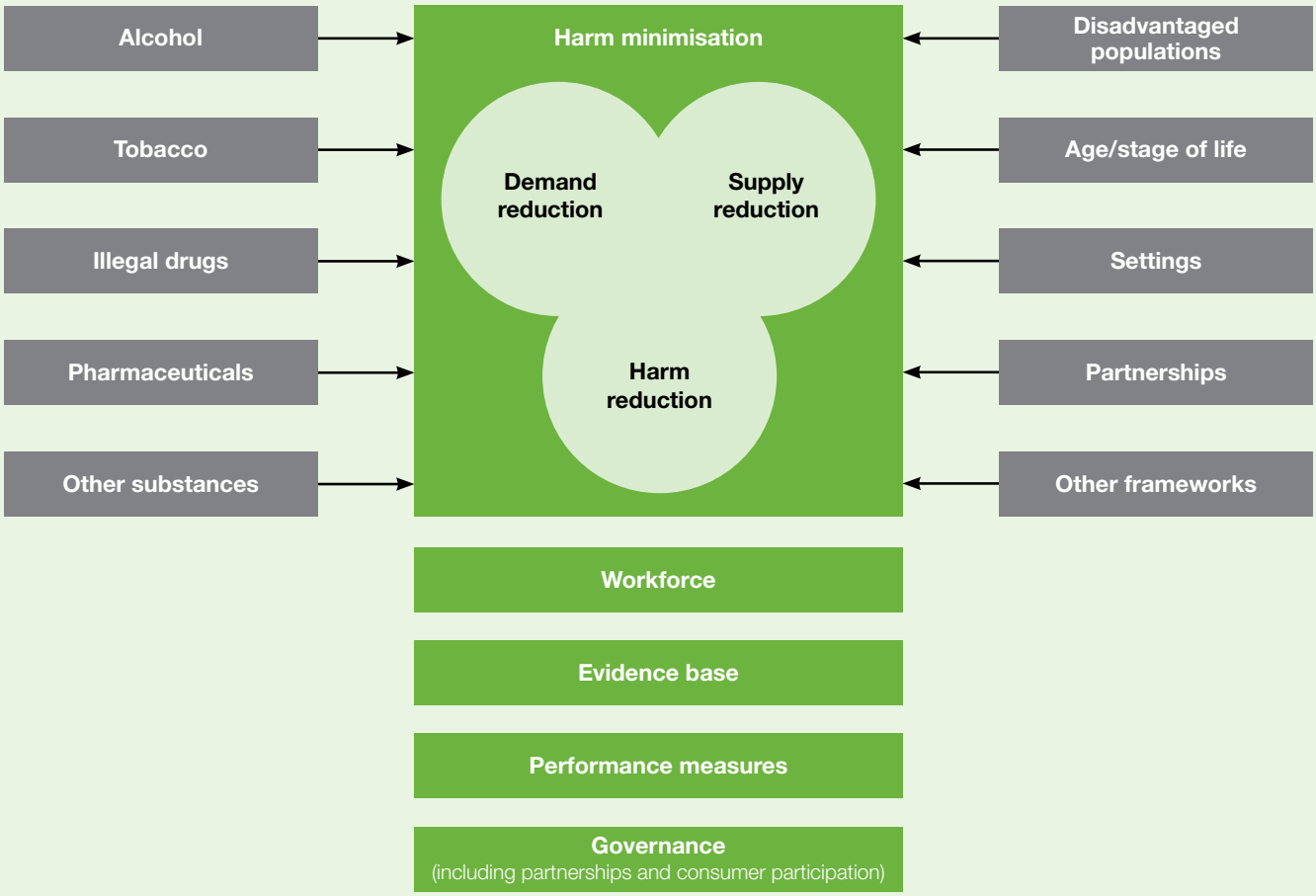


Figure 1 illustrates the approach that will be taken to implement the harm minimisation framework under the *National Drug Strategy 2010–2015*:

- The three pillars apply across all drug types but in different ways. For example, supply reduction of legal drugs refers to regulation of supply, but for illegal drugs means disruption of supply. This is covered in more detail against each pillar.
- The approaches within the three pillars need to be sensitive to age and stage of life, disadvantaged populations and settings of use and intervention. People may be more vulnerable to experimenting with drugs at transition points such as moving from school to work. The workplace, schools, licensed premises and communities need to be considered as settings for possible interventions. The potential of new media, such as social networking sites on the internet, to deliver interventions also needs to be considered. Integrated cross-sectoral approaches may be needed for disadvantaged populations such as people with co-occurring mental health and alcohol and other drug-related problems. These are explained in more detail below and against each pillar.
- The three pillars will be underpinned by commitments to:
  - partnerships across sectors
  - consumer participation in governance
  - building the evidence base, evidence-informed practice and innovation
  - monitoring performance against the strategy and its objectives
  - developing a skilled workforce that can deliver on the strategy.

These supporting approaches are covered in Part 3 of the strategy.

Successes of the National Drug Strategy

Since the inception of the National Campaign Against Drug Abuse in 1985, Australia has had major successes in reducing the prevalence of, and harms from, drug use.

- Far fewer Australians are **smoking** and being exposed to second-hand smoke as a result of comprehensive public health approaches, including bans on advertising, bans on smoking in enclosed public spaces and significant investments in public education and media campaigns. The daily smoking rate among Australians aged 14 years and over has fallen from 30.5 per cent in 1988 to 16.6 per cent in 2007.
- Far fewer people are using **illegal drugs**. The 2007 National Drug Strategy Household Survey shows the proportion of people reporting recent use of illegal drugs fell from 22 per cent in 1998 to 13.4 per cent in 2007. The recent use of cannabis—the most commonly used illegal drug—fell from 17.9 per cent in 1998 to 9.1 per cent in 2007.
- Law enforcement agencies have continued to be effective in detecting and seizing illegal drugs to disrupt supply. The number of illegal drug **seizures** increased by almost 70 per cent between 1999–2000 and 2008–09, and the collective weight of seizures increased by about 116 per cent.
- The **heroin** shortage that began in 2000 has been sustained, with heroin use remaining at low levels since then.
- Harms associated with **injecting drug use** have also been reduced. It is estimated that from 2000–2009 needle and syringe programs, which ensure the safe supply and disposal of syringes to injecting drug users, have directly averted over 32 000 new HIV infections and nearly 97 000 hepatitis C infections.
- Since its introduction in September 2005 non-sniffable *Opal* fuel has contributed to a 70 per cent reduction in **petrol sniffing** across 20 regional and remote communities in Western Australia, South Australia, the Northern Territory and Queensland.
- Early intervention and **diversion programs**, which help prevent young people and adults apprehended for drug use from getting caught up in the criminal justice cycle by diverting them to treatment interventions, have become an established and successful part of the harm minimisation approach.
- **Drink driving** has become largely unacceptable within the general Australian population. There was a substantial reduction in alcohol-related road deaths between the mid 1970s and the early 1990s through mass breath testing of drivers, lower and nationally consistent driver blood alcohol content limits, zero limits for special driver groups, a system of penalties, mass public education and media campaigns and other road safety initiatives.
- Far more is known about what works in the **treatment** of alcohol and other drug dependence, including through brief interventions, detoxification, pharmacological and psychosocial treatment approaches.

Challenges for 2010–2015

Many challenges still remain. The following have been identified as drug-specific priorities for 2010–2015:

- Risky drinking, drinking to intoxication and **alcohol**-related disease, injury and violence continue to cause significant harms in the community. An estimated 813 072 Australians aged 15 years and older were hospitalised for alcohol-attributable injury and disease over the 10-year period 1995–96 to 2004–05. Rates of alcohol-attributable hospitalisations increased in all states and territories. Alcohol remains a leading cause of Australian road deaths, particularly among young people.
- **Smoking** rates continue to be unacceptably high in the general population—16.6 per cent smoked daily in 2007—and particularly among Aboriginal and Torres Strait Islander people, of whom around 45 per cent smoked daily in 2008. The Council of Australian Governments (COAG) has agreed in the National Healthcare Agreement 2008 to targets of reducing the prevalence of smoking in the Australian population to 10 per cent by 2018 and to halving the smoking rate among Aboriginal and Torres Strait Islander peoples.
- Changing patterns of use of, and harms from, **illegal drugs** need to be continually monitored and responded to. At the time of writing in 2010, emerging trends included:

- increasing **harms from cannabis**. The number of older users presenting to hospital with dependence and other cannabis-related problems increased markedly between 2002–07 and nearly doubled among users aged 30–39. Hospital presentations for cannabis-induced psychosis were highest among users aged 20–29. The number of hospital outpatient treatment episodes for cannabis-related problems increased by 30 per cent. Cannabis cultivation continues to be an activity of interest for organised crime.
- continuing high demand for **ecstasy** and domestic production of **amphetamine type stimulants** (ATS). Self-reported recent use of ecstasy increased from 2.4 per cent in 1998 to 3.5 per cent in 2007 with particularly concerning increases among young women. ATS arrests more than doubled between 1999–2000 and 2008–09. Manifestations of extreme behaviour in ATS users, including violence, increases risks for police, ambulance, and hospital emergency department workers, as well as users and the community. Organised crime involvement in manufacturing and trafficking ATS is also a concern.
- an expansion of the **cocaine** market is reflected in recent increases in cocaine arrests, seizures and reported use. Two distinct user groups have been identified. The first is employed, well-educated and socially integrated individuals and the second injecting drug users.
- while rates of heroin and other injecting drug use have stabilised at low levels, harms from ongoing heroin and other **injecting drug use** persist, particularly in relation to blood-borne virus infections and overdose.
- new '**analogue**' drugs—derivatives or substances similar in chemical structure to illegal drugs—are emerging, particularly in sales over the internet. Many of these substances have not yet been captured under the drug law schedules which govern their legal status.

- The harms from drug use are potentially amplified by the increasing pattern of **poly-drug use**—the concurrent use of more than one drug. Alcohol is the drug most commonly used in this way. For example, it is often used with legal drugs resulting in unpredictable consequences. More recently it is increasingly mixed with highly-caffeinated products/other stimulants ('energy drinks'). Mixing of drugs can multiply the effects of each drug, increase adverse reactions and the unpredictability of the reactions and even increase the risk of overdose.
- **Pharmaceutical drug misuse**. The most commonly misused pharmaceuticals include opioids, benzodiazepines, codeine, the stimulants methylphenidate (Ritalin) and dexamphetamine and performance-enhancing drugs such as steroids. Diversion and misuse of opioid drugs is widespread and prevalent where heroin is not readily available. Misuse also occurs among poly-drug users and those with chronic pain. An extra challenge is balancing the legitimate use of, and access to, pharmaceuticals with the need to prevent harms caused by misuse.

There are a number of structural priorities for 2010–2015:

- The **internet** poses both challenges and opportunities for the National Drug Strategy. It is an efficient channel for information on illegal drug manufacture and use, and a difficult to regulate advertising medium for alcohol and tobacco. However, it also provides opportunities for providing information, and potentially treatment, to audiences who may not be reached through other media.
- **Planning and quality frameworks for treatment services** need to incorporate evidence into successful drug treatments.
- Continued work is needed with the **mental health sector** to improve links and coordination between the two sectors to support individuals with co-occurring mental illness and alcohol and other drug use, and their families.
- **Data collection and management** is vital to the delivery and evaluation of services and broader policy development. Enhancing the data that is available and how it is used will help inform efforts under the National Drug Strategy.

Age and stage of life

It is well recognised that people are at greater risk of harm from drugs at points of life transition. These include transitioning from primary to high school, from high school to tertiary education or the workforce, leaving home and retiring.

- Drinking alcohol in adolescence can be harmful to young people's physical and psychosocial development. Alcohol-related damage to the brain can be responsible for memory problems, an inability to learn, problems with verbal skills, alcohol dependence and depression.

- The Australian Secondary School Students Alcohol and Drug Survey has consistently shown that fewer students are smoking overall. However, the secondary school years remain a key risk period for the uptake of smoking, with higher rates in each age group from 12 years onwards through adolescence.
- The adolescent drive to take risks and the need for coping mechanisms during adolescence can be major influences on the uptake of illegal drugs by teenagers.
- Young people are more at risk of motor vehicle accidents, injuries, accidental death and suicide whilst under the influence of alcohol and drugs. They are also highly susceptible to being victims of crime.

The *National Drug Strategy 2010–2015* recognises the challenge of long-term drug use and misuse among adults and the new challenges that an ageing population may pose.

- Daily cannabis use is most common amongst 40–49 year olds. This age group is nearly twice as likely as 14–19 year olds to report daily use. This is despite an overall decline in the proportion of the population reporting recent use of cannabis.
- The proportion of Australians aged 65 years or older is expected to increase from 12.1 per cent currently to 24.2 per cent by 2051. Older people face particular issues with drug misuse including interactions with prescribed medications, under-recognition and treatment of alcohol and drug problems, unintentional injury and social isolation. Alcohol can increase the risk of falls, motor vehicle accidents and suicide in older people.

Disadvantage and social isolation

Drug use can have a significant impact on disadvantaged groups and lead to intergenerational patterns of disadvantage.

- There is strong evidence of an association between social determinants—such as **unemployment, homelessness, poverty, and family breakdown**—and drug use. Socio-economic status has been associated with drug-related harms such as foetal alcohol syndrome, alcohol and other drug disorders, hospital admissions due to diagnoses related to alcoholism, lung cancer, drug overdoses and alcohol-related assault. In the 2007 National Drug Strategy Household Survey the highest prevalence of recent illegal drug use was reported by unemployed people—23.3 per cent compared with 13.4 per cent of the general population. Alcohol, tobacco and other drug use among homeless people is common. One study estimated the overall 12-month prevalence of harmful alcohol use for homeless people in Sydney at 41 per cent and the prevalence of drug use at 36 per cent. Family factors—including poor parent–child relationships, family disorganisation, chaos and stress and family conflict and marital discord with verbal, physical or sexual abuse—also have a strong association with drug use. There are a number of strong protective factors that guard against problematic alcohol and other drug use. These include having a job, a stable family life and stable housing. These factors can be important in preventing or overcoming drug-related problems.
- Smoking is the primary cause of chronic disease among **Aboriginal and Torres Strait Islander peoples**. In 2003 smoking was responsible for one-fifth of deaths and accounted for 12 per cent of the total burden of disease among Aboriginal and Torres Strait Islander peoples. In 2004–05, 55 per cent of Aboriginal and Torres Strait Islander peoples aged 18 years and over reported drinking at short-term risky or high risk levels on at least one occasion in the previous 12 months.
- Despite a sustained decline in the prevalence of smoking among people in major cities, the decline has been slower among people living in **regional and remote** areas. Men in these areas were significantly more likely than those in major cities to report risky or high-risk alcohol consumption.
- Thirty-five per cent of people who use drugs also have a co-occurring **mental illness**. Although people with mental illness benefit from alcohol, tobacco and other drug treatment, they have poorer physical and mental health and poorer social functioning following treatment than other people.
- People in **prison** have underlying high rates of drug use. In 2009, 81 per cent of prison entrants were current smokers and 74 per cent smoked daily, 52 per cent of prison entrants reported drinking alcohol at levels that placed them at risk of alcohol-related harm and 71 per cent of prison entrants had used illegal drugs in the 12 months prior to their current incarceration. Injecting drug use and the associated risk of blood-borne virus infection is a particular issue for prison populations. Among prison entrants, 35 per cent tested positive for hepatitis C.

- Some **culturally and linguistically diverse** (CALD) populations may have higher rates of, or are at higher risk of, drug use. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia's more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting.
- People from disadvantaged or marginalised groups, such as **gay, lesbian, bisexual, transgender and intersex** populations, may also experience more difficulty in accessing drug treatment and achieving successful outcomes from that treatment unless it is appropriate for their particular needs. Those who are most at risk are people with **multiple and complex needs**. This may involve a combination of drug use, mental illness, disability and injury, family breakdown, unemployment, homelessness and/or having spent time in prison.

Under the *National Drug Strategy 2010–2015*, **socially inclusive strategies** and actions are needed that recognise the particular vulnerabilities and needs of these disadvantaged groups.

Settings

Settings-based approaches are also a key feature of the *National Drug Strategy 2010–2015*.

Priority settings for possible preventive interventions on alcohol, tobacco and other drugs will include **families, educational settings, workplaces, licensed premises and communities**.

More attention is needed to address drug use among **prison** populations. This includes addressing supply reduction in the prison environment, reducing demand through education and treatment and approaches for reducing harm. Attention is also needed to help prevent drug use from continuing or recurring when people leave prison.

More focus will also be placed on the **internet** as an important emerging medium for prevention and treatment approaches and as a potentially effective tool for reaching new or hard to reach settings.

Partnerships

Since its inception the National Drug Strategy has been underpinned by strong **partnerships**, particularly across the health and law enforcement sectors, between the government and non-government sectors, and among policy-makers, service providers and experts.

For 2010–2015 the **health–law enforcement** partnership will remain at the centre of the strategy. However, this partnership will be extended to other sectors as appropriate, including **education**, particularly to help tackle the more complex causes of, and harms from, drug use in the present environment (see Supporting approaches: Governance).

In relation to alcohol, partnerships continue to be needed with **liquor licensing authorities, local governments** including town planners and transport authorities and **local communities** to help reduce potential harms. Collaborative partnerships with business also need to be maintained both for regulatory issues and preventative approaches in workplaces.

Strong partnerships and **integrated service approaches** with **alcohol and other drug treatment, social welfare, income support and job services, housing and homelessness services, mental health care providers** and **correctional services** are needed if people with multiple and complex needs are to be assisted to stabilise their lives, reintegrate with the community and recover from alcohol and other drug-related problems.

Closer integration with **child and family services** is needed to more effectively recognise and manage the impacts of drug use on families and children.

Ongoing partnerships with **Aboriginal and Torres Strait Islander communities** are also needed to help reduce the causes, prevalence and harms of alcohol misuse and tobacco and other drug use among Aboriginal and Torres Strait Islander peoples.

Finally, Australia needs to engage in **international partnerships** to maximise the effectiveness of law enforcement efforts, to learn and share best practice demand, supply and harm reduction approaches and to help enhance our regional neighbours' efforts to respond to the problem of drug use. Under the *National Drug Strategy 2010–2015*, Australia will continue to actively engage in multilateral forums for international cooperation on alcohol, tobacco and other drug issues, including the World Health Organization and its implementation of the Global Alcohol Strategy, the United Nations Office on Drugs and Crime, the Conference of the Parties to the World Health Organization Framework Convention on Tobacco Control and the United Nations Commission on Narcotic Drugs. The Australian Federal Police and the Australian Customs and

Border Protection Service will continue to cooperate with their international counterparts on drug investigations. Australian health and law enforcement agencies and non-government organisations will also continue to engage with developing countries, particularly in the Asia-Pacific region, to provide assistance on drug-related problems where such assistance is needed.

Sub-strategies

A number of sub-strategies sit under the umbrella of the *National Drug Strategy 2010–2015*. These sub-strategies provide direction and context for specific issues, while maintaining the consistent and coordinated approach to addressing drug use, as set out in this strategy. In particular, the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan was developed to provide national direction on drug-related problems that concern Aboriginal and Torres Strait Islander peoples.

During the life of the *National Drug Strategy 2010–2015*, seven sub-strategies will be updated or developed to address specific priorities:

- National Aboriginal and Torres Strait Islander Peoples Drug Strategy
- National Alcohol Strategy
- National Tobacco Strategy
- National Illicit Drugs Strategy
- National Pharmaceutical Drug Misuse Strategy
- National Workforce Development Strategy
- National Drug Research and Data Strategy.

Standing committees and working groups of the Intergovernmental Committee on Drugs (see Supporting approaches: Governance) will be responsible for the development of these sub-strategies. Best efforts will be made to synchronise the timing of these sub-strategies.

There are also national strategies and frameworks in other sectors relevant to the work of the *National Drug Strategy 2010–2015*, where efforts are needed to integrate and leverage complementary approaches. These frameworks are listed in Appendix A.

2. The Pillars

This part of the National Drug Strategy sets out the objectives of, and actions against, each of the three pillars of the Australian harm minimisation approach—demand reduction, supply reduction and harm reduction. Each of the pillars is equally important to the success of the strategy.

The objectives and actions listed under each pillar are not exhaustive but provide a general explanation of what is involved.

The approach and the actions specified take into consideration differences across drug type, disadvantaged populations, age and stage of life and settings.

Pillar 1: Demand reduction

Demand reduction includes strategies to prevent the uptake of drug use, delay the first use of drugs, and reduce the misuse of alcohol, and the use of tobacco and other drugs. This includes providing information and education, for example through school-based programs or public-awareness campaigns. Evidence-based early intervention programs, diversion, counselling, treatment, rehabilitation, relapse prevention, aftercare and social integration can help drug users reduce or cease their drug use. The demand for drugs can also be affected by their availability and affordability which can, depending on the drug, be influenced through supply control, regulation and taxation.

People use drugs for a range of reasons including as an integral part of social behaviour, to experiment, because of peer pressure, to escape or cope with stress or difficult life situations or to intensify feelings and behaviours. Drug use is influenced by a complex interaction of physical, social and economic factors. Disadvantaged populations are at heightened risk of drug misuse and its associated harms. People can also be at risk of different patterns of use at different ages. For example, younger people may be more at risk of short-term harms from alcohol use while older people may be more at risk from chronic alcohol misuse.

The appropriate mix of educational and social marketing approaches will vary by drug type. Whole-of-population strategies may be more appropriate for alcohol and tobacco and for those illegal drugs that are widely used, while approaches targeted to users and at-risk groups may be more appropriate for those drugs only used by a small percentage of the population.

Settings-based approaches will be an important feature of the *National Drug Strategy 2010–2015*. The COAG Preventive Health National Partnership Agreement includes a focus on prevention activities for alcohol and tobacco in communities, childcare and school settings and workplaces. Other settings such as prisons also require planned and comprehensive demand-reduction strategies.

No one strategy on its own can prevent and reduce the demand for drugs. Rather, broad-based, multidisciplinary and flexible strategies are needed to meet the varied needs of individuals and communities.

Demand reduction requires the cooperation, collaboration and participation of a diverse range of sectors. It is important to recognise the range of sectors that can influence drug demand and to develop closer links with them.

Objective 1:

Prevent uptake and delay onset of drug use

Preventing drug use can be more cost-effective than treating established drug-related problems. Prevention efforts can help reduce personal, family and community harms, allow better use of health system resources, generate substantial economic benefits and produce a healthier workforce.

A key step in preventing the uptake of drugs is changing the culture so that drug misuse is no longer seen as a cultural norm. This involves improving community understanding and awareness of the drugs being used, their effects, the harms associated with their misuse and the choice of effective interventions and treatment. For some drugs, such as tobacco, cultural acceptance by a large portion of the population has been successfully challenged, contributing to a significant reduction in use over many years. Harmful alcohol consumption, on the other hand, still remains a challenge.

There is an increased risk of harms associated with the early uptake of drugs. The earlier a person commences use, especially heavy use, the greater their risk of harm in the short and longer term (such as mental and physical health problems) and the greater their risk of continued drug use.

Actions

- Explore and implement strategies that contribute to the development of a culture that promotes healthy lifestyles.
- Develop and implement treatment and family-support strategies that can prevent and break patterns of drug use, including intergenerational patterns.
- Work collaboratively with other national policies to reduce risk factors and build protective factors, while recognising the diverse range of influences on drug use.
- Continue to implement and support well-planned social marketing campaigns that address the risks of alcohol, tobacco and other drug use, the risks of specific drug use practices (such as injecting) and promote healthy lifestyles and safer drinking cultures, including targeted approaches and local complementary initiatives for different population groups.
- Use the internet and other media to sustain and strengthen the provision of credible and accurate information about alcohol, tobacco and other drugs to target particular population groups.
- Limit or prevent exposure to alcohol and tobacco advertising, promotion and sponsorship through regulation and, where appropriate, voluntary and collaborative approaches with business.
- Explore ways of influencing responsible media reporting and portrayal of alcohol, tobacco and other drug use.
- Support community-based initiatives, including in Indigenous communities, to change the culture of smoking, harmful alcohol use and other drug use.
- Improve the application of evidence-based whole-of-school drug education policies and programs.

Objective 2:

Reduce use of drugs in the community

The effects of the use of drugs go beyond injury and illness or disease to a range of social and economic consequences. People experiencing problems with drugs can find it difficult to form or maintain relationships, may have their educational and vocational paths disrupted and their general social development hampered. To reduce the occurrence and cost of such problems, interventions need to be implemented early, preferably before problems emerge. For dependent users, reducing and/or ceasing the use of drugs can help them to lead more stable, healthy and productive lives.

Successfully reducing the misuse of alcohol, and the use of tobacco and other drugs requires a range of approaches across the continuum of use, from experimental to dependent use. It is important to ensure that appropriate treatment is available and accessible. Engaging the support of family and friends for those seeking treatment is an important part of helping people reduce their drug use.

Brief interventions can also be very effective. Brief interventions aim to identify current or potential problems with drug use and motivate those at risk to change their behaviour. They can range from five minutes of brief advice to 30 minutes of brief counselling. Brief interventions are commonly delivered by general practitioners and alcohol and other drug workers, but can also be used by other service providers, police officers, mental health workers, nurses or family members.

In instances of dependence, it is important for people to have access to effective and affordable treatment services and where needed, support for rebuilding their lives and reconnecting with the community. Evidence supports the effectiveness of a range of appropriately targeted treatment approaches. However, people can find it difficult to locate and access the service that meets their needs and people with multiple and complex needs have the added difficulty of finding a number of different, sometimes unrelated, services in a timely way.

A range of appropriate, specialised services should be available to anyone with a drug-related problem, irrespective of personal history, circumstances or socioeconomic status. A 'no wrong door' approach should be adopted so that people are provided with, or are guided to, appropriate services regardless of where they enter the system of care.

Generalist health care and social welfare services should also notice, assess and respond to people with alcohol, tobacco and other drug-related problems. There is a range of brief interventions, for example, that can be delivered by generalist services or over the internet. These could refer people to specialised services where necessary or provide support before harms and long-term dependence occur.

Actions

- Build on efforts to increase the range of, access to and links between evidence-based treatment and other support services.
- Sustain efforts to increase access to a greater range of culturally-sensitive services.
- Improve access to screening and targeted interventions for at-risk groups such as young people, people living in rural and remote communities, pregnant women and Aboriginal and Torres Strait Islander peoples.
- Increase the community's understanding of effective drug interventions by providing factual, credible information.
- Continue efforts in diverting people from traditional criminal justice pathways by providing information and/or referring them to assessment and treatment.
- Increase awareness, availability and appropriateness of evidence-based telephone and internet counselling and information services.
- Strengthen the capacity of the primary healthcare system to manage prevention, early intervention and treatment of tobacco use and harmful alcohol use.
- Develop planning models for treatment services that anticipate needs.
- Develop and implement quality frameworks for treatment services.
- Create incentives for people who misuse drugs or are dependent to access effective treatment and to make healthier choices.
- Encourage family members to access and make use of support services to help improve treatment outcomes for clients.
- Explore and develop opportunities in the criminal justice system, including correctional services, to assist drug users through education, treatment and rehabilitation services.

Objective 3:

Support people to recover from dependence and reconnect with the community

Recovering from drug dependence can be a long-term process in which individuals need support and empowerment to achieve independence, a healthy self-esteem and a meaningful life in the community. Successful support for longer-term recovery after treatment requires strategies that are focused on the whole individual and look across the life span.

While different people will have different routes to recovery, support for recovery is most effective when the individual's needs are placed at the centre of their care and treatment. Treatment service providers can help individuals recover from drug dependence, help the individual access the internal resources they need (such as resilience, coping skills and physical health) and ensure referral and links to a range of external services and support (such as stable accommodation, education, vocational and employment support and social connections).

In maintaining and strengthening the current system of treatment and other support services across jurisdictions, the following principles will be continued under the National Drug Strategy:

- In designing treatment services, it is important to recognise that drug users are not a homogenous group. Treatment services should incorporate a principle of consumer involvement in planning and operations. Treatment interventions should also be tailored to the varying needs of individuals (including the potential for access to substance-specific treatment and services).

- In designing and coordinating referral pathways, it is important to recognise that trigger points for entry into treatment come from a broad range of sources which should be reflected in those pathways. These include through alcohol and other drug diversion programs and links with primary health care.
- In designing and coordinating support after treatment to help individuals rebuild their lives and reconnect with the community, it is important to recognise that individuals often become marginalised or socially isolated as a result of their drug use, losing touch with their families and friends as well as opportunities for education, vocational, employment, housing and other areas of social participation. Furthermore, all services need to work together to reduce stigma attached to seeking treatment. Drug treatment alone cannot solve these problems which, if not dealt with, can place an individual at risk of relapsing to drug use and related issues. Consequently, it is important that treatment services are linked to a broader range of services able to provide these supports and the necessary relationships and processes developed to better ensure these links are effective.

Actions

- Develop new evidence-based national planning tools to help jurisdictions better estimate the need and demand for alcohol and other drug health services across Australia. This should include the full spectrum of services from prevention and early intervention to the most intensive forms of care, and a range of services across the life span.
- Develop a set of national clinical standards for alcohol and other drug treatment services.
- Improve the links and coordination between primary health care and specialist alcohol and other drug treatment services to enhance the capacity to deal with all health needs and to facilitate the earlier identification of health problems and access to treatment.
- Improve the communication and flow of information between primary care and specialist providers, and between clinical and community support services to promote continuity of care and the development of cooperative service models.
- Investigate appropriate structures that could be developed to help engage families and other carers in treatment pathways and ensure that information about the pathways is readily accessible and culturally relevant.
- Identify and link the necessary services to provide those affected by drug use and dependence, such as family members, children and friends, with ongoing support including links to child welfare and protection services.
- Move towards a nationally consistent approach for non-government treatment services including quality frameworks and reporting requirements.
- Develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence, help seeking and the related problems of individuals.
- Improve links and coordination between health, education, employment, housing and other sectors to expand the capacity to effectively link individuals from treatment to the support required for them to reconnect with the community.

Objective 4:

Support efforts to promote social inclusion and resilient individuals, families and communities

Socially inclusive communities and resilient individuals and families are less likely to engage in harmful drug use. Resilient individuals can adapt to changes and negative events more easily and reduce the impacts that stressors have on their lives—and are less likely to use drugs.

Resilient and inclusive communities are characterised by strong social networks and work together to support individuals who need assistance. They also promote safe and healthy lifestyles. Supportive and informed families and communities can prevent the uptake of drug use, identify drug use in its early stages and help individuals access and maintain treatment. A resilient community will support people to avoid relapse and help them reconnect with the community.

Responsibility for building resilient communities lies at all levels—from governments, to communities, non-government organisations, families and individuals.

Actions

- Support whole-of-government and whole-of-community efforts to build parenting and family capacity, creating communities that support the positive development of children. This may include evidence-based approaches to drug prevention in schools.
- Continue to implement skills training to provide individuals with coping skills to face situations that can lead to risky behaviour including harmful drug use.
- Implement preventive support programs targeting life transition points—primary to secondary school, secondary school to tertiary education, school to work and prison to community—to help individuals develop the skills to manage the next stage of life.
- Support efforts to encourage participation of at-risk groups in community life including recreational, sporting and cultural activities.
- Provide support services to parents in recovery to ensure the needs of dependent children are met.

Pillar 2: Supply reduction

Supply-reduction strategies are directed toward enforcing the prohibition of illegal drugs and regulating and enforcing access to legal drugs, including alcohol, tobacco, pharmaceuticals and other drugs. In the case of illegal drugs, supply-reduction activities, including both border and domestic policing, extend to controlling the availability of precursor chemicals and equipment used for manufacturing drugs. It also extends to compliance with Australia's obligations under international drug control treaties.

Reducing the supply of drugs requires the collaborative participation of all levels of government including law enforcement and the health sector (public and private), industry and regulatory authorities.

It also requires engaging the Australian community and their support for these strategies. The message must be clear that the supply and use of illegal drugs and the illegal supply and misuse of tobacco, alcohol, pharmaceuticals and other legal drugs is not acceptable.

For alcohol, tobacco, pharmaceuticals and other legal drugs, government authorities, and community and business organisations need to collaborate to regulate access to these drugs based on community expectations and standards, and the costs and benefits of their use. For alcohol, this means that liquor licensing, planning authorities, local government, licensed venues and retailers need to be involved. Parents and families also have a role in reducing the supply of alcohol to minors. A wide range of businesses and retailers need to be involved in regulatory and collaborative approaches to reducing harms from alcohol.

For tobacco, the involvement of retailers is essential. For pharmaceutical drugs, doctors and pharmacists need to be consulted and involved in supply-reduction strategies to reduce pharmaceutical misuse. Retailers of other substances (such as inhalants) are essential partners in the regulation and enforcement of supply.

For illegal drugs, law enforcement strategies are needed which target all parts of the supply chain from actions aimed at preventing importation across the border to those that target the point of supply to consumers. The increasing prevalence in the use of the internet to facilitate the global supply of illegal drugs—particularly those marked as 'party pills' and 'legal highs'—also needs to be considered in these strategies. Communities—not only in metropolitan areas but also in rural and remote areas and Aboriginal and Torres Strait Islander communities—have an important role to play in not tolerating illegal drug supply and helping law enforcement to combat this.

There is a strong connection between the supply of illegal drugs and the illegal supply of legal drugs because of the financial proceeds that arise from such activities. Therefore the disruption of organised crime and money laundering is an important component of any drug supply-reduction strategy. The disruption and dismantling of organised crime is a high priority for governments as reflected in the Australian Government's Commonwealth Organised Crime Strategic Framework.

Objective 1:

Reduce the supply of illegal drugs (both current and emerging)

Reducing the supply of illegal drugs requires activity at Australia's borders to prevent and disrupt importations of illegal drugs and their precursors and within Australia to prevent cultivation, manufacture and distribution of illegal drugs. Legislative frameworks exist and require constant enforcement to ensure a reduction in the supply of illegal drugs.

These frameworks need to be supported by demand-reduction strategies which engage the health sector and community and raise awareness of the harms and consequences arising from illegal drug use.

Border activities are crucial in controlling the importation of illegal drugs and Australia must continue to develop strong international partnerships and help strengthen the capability of our international partners, particularly in the Asia-Pacific region, to manage borders. It is important too that Australia continues to participate in international law enforcement activities, such as those coordinated by the United Nations Office on Drugs and Crime.

The illicit drug market is not only constrained by international borders. Information sharing and coordinated approaches are needed to stem the supply of illicit drugs at all stages from the supply chain from overseas suppliers, interception at the border (jurisdictional and international) and investigation and prosecution of domestic producers, manufacturers and suppliers.

Actions

- Prevent the importation of illegal drugs and control the legitimate trade of equipment and chemicals used in their manufacture.
- Increase and improve enforcement targeting cultivation, manufacture and trafficking of illegal drugs, including the financial proceeds arising from these activities.
- Improve powers of detection through supportive technology (and systems), access to relevant information and workforce development.
- Strengthen collaboration between law enforcement, industry and relevant agencies to prevent the diversion of precursor chemicals into the manufacture of illegal drugs.
- Improve cooperation and collaboration between law enforcement agencies, especially with respect to information and intelligence access and exchange.
- Develop closer relationships with international partner agencies and bodies and enhance Australia's national approach to implementing its obligations under international drug control treaties.
- Build on Australia's capacity to use the border as a significant choke point for the supply of illegal drugs into Australia through promoting nationally consistent drug control laws, which would also limit the opportunity for organised crime to exploit legislative inconsistencies.
- Ensure the ongoing and timely review of legislation and regulation to reflect the dynamic nature of illegal drug markets and manufacture.
- Research, investigate and gather information on all aspects of drug supply markets including identifying emerging drugs and manufacturing techniques to properly inform law enforcement responses.
- Foster research and development in technological innovation to provide investigative tools for use in the disruption of the supply markets.

Objective 2:

Control and manage the supply of alcohol, tobacco and other legal drugs

Supply reduction for alcohol, tobacco and other legal drugs involves activities targeted towards the regulation of legitimate supply and the detection and interruption of illegal markets.

Regulation of the sale of alcohol focuses on who can sell alcohol, to whom and when, by ensuring that alcohol is sold only to adults and only by licensed premises and liquor retailers. State, territory and local government regulations control these and other conditions of sale in the community, to minimise the negative social impact of alcohol. Licensees and hospitality workers have a responsibility for limiting supply to intoxicated people or removing them from licensed premises with the assistance of licensing inspectors and police. Parents, siblings, and friends are the main sources of supply of alcohol to young people and therefore have a key role to play in reducing access to alcohol by this group.

Similarly, age restrictions on tobacco sales need to be enforced and retailers and families have a responsibility to reduce access by young people. The illegal cultivation, sale and supply of tobacco and the importation and distribution of kava and khat exceeding the permitted amount require appropriate regulation and enforcement.

An emerging and challenging issue is the misuse of pharmaceutical drugs—including opioids, stimulants and performance- and image-enhancing drugs. An effective supply reduction response will require a collaborative cross-sectoral approach that balances the need to ensure the availability of these drugs for medicinal purposes while, at the same time, restricting illegal access and diversion to illegal drug markets. Legislative and regulatory frameworks exist and require constant monitoring to ensure they support the appropriate prescribing and supply of pharmaceutical drugs. These frameworks also need to be supported by demand-reduction strategies such as information and education campaigns that engage the health sector and community and serve to raise awareness of this issue.

For legal substances like inhalants (such as petrol, paint and glue) that are readily misused, a balance also needs to be found between access for legitimate purposes and regulation of supply. This balance needs to take account of the prevalence of misuse and the harms from these substances.

Actions

- Improve and strengthen the regulatory framework surrounding the promotion, sale and supply of legal drugs (both from domestic and overseas sources) to prevent their diversion, misuse and consequent harm.
- Increase and improve the enforcement of regulatory mechanisms concerned with the supply and availability, including via the internet, of legal drugs that are subject to misuse and harm.
- Target the illegal importation and illegal supply and cultivation of tobacco.
- Participate in negotiations to finalise the Protocol to Eliminate the Illicit Trade in Tobacco Products under the WHO Framework Convention on Tobacco Control.
- Further foster relationships between all levels of government with industry, relevant agencies and the community to assist in regulating and reducing inappropriate access to legal drugs that are subject to misuse and harm.
- Improve the capacity of law enforcement, health professionals and agencies, industry groups and other relevant agencies by developing supportive systems or technology to identify and respond to the inappropriate use of legal drugs.
- Increase training and support for those at the point of supply of pharmaceutical drugs (such as doctors, pharmacists and veterinarians) to reduce the inappropriate supply, misuse and diversion of these drugs into the black market.

- Increase training and support for those at the point of sale of alcohol to reduce the inappropriate supply of alcohol and in particular the supply of alcohol to young people.
- Consider the development of a set of national principles on liquor licensing.
- Increase the community's understanding of the inappropriate supply and diversion of alcohol, tobacco, pharmaceutical and other legal drugs and the associated consequences through targeted public information campaigns, information sharing and social marketing.
- Research, investigate and gather information on all aspects relating to the supply of alcohol, tobacco and other legal drugs, including the impact on individuals and the community.
- Research the effectiveness of strategies aimed at curtailing the inappropriate supply of alcohol, tobacco and other legal drugs.

Pillar 3: Harm reduction

Harm reduction works to reduce the adverse health, social and economic impacts of drug use on communities, families and individuals.

An individual's engagement in drug use, illegal drug supply or illegal drug manufacture generally has flow-on health, social, economic, environmental and other consequences. These consequences extend to family, the workplace, neighbourhoods, the community and the individual.

In relation to alcohol, efforts to prevent drink driving and reduce the incidence of alcohol-related road accidents have been a key harm-reduction approach over a long period. Programs and interventions to tackle risky drinking, including liquor licensing and responsible service of alcohol, education and information programs and community-based approaches, have aimed to reduce alcohol-related public violence. Brief interventions, treatment for alcohol dependence and family support services can help reduce the incidence and impact of family conflict and violence.

In relation to tobacco, harm-reduction efforts have included minimising exposure to second-hand smoke through bans on smoking in workplaces and enclosed public spaces and, in some jurisdictions, bans on smoking in cars where children are present.

In relation to injecting drug use, needle and syringe programs have been the main harm-reduction approach, helping to slow the spread of blood-borne viruses like HIV and hepatitis C. Readily available needle disposal facilities and other strategies as simple as well-lit streets have helped improve community amenity in areas where injecting drug use takes place. Some jurisdictions have used innovative approaches, including a medically supervised injecting centre in one jurisdiction.

For illegal drugs more generally, programs to divert offenders from the criminal justice environment into treatment or other health interventions have helped increase the chances of recovery and reduce the likelihood of individual recidivism harming the community. Strategies to prevent and effectively manage drug overdose have also been important harm-reduction responses. In addition, some jurisdictions have implemented road-side drug testing to detect and deter drug-impaired driving.

Other harm-reduction approaches have included the provision of chill-out spaces, water, information and peer support and emergency medical services at events where drug use may be occurring.

Objective 1:

Reduce harms to community safety and amenity

A significant and sometimes overlooked harm from drug use is the impact it can have in reducing the extent to which people feel safe in their communities. Heavy alcohol consumption can lead to threats and assaults, vandalism, public disorder and road accidents. Illegal drug use—particularly injecting drug use—can affect people's perceptions of the safety of their community and the business confidence of an area. The illegal drug trade and drug use contributes to significant social costs through property crime and violence.

As higher-density living becomes the norm in our cities, greater attention is needed on public safety and health services, and supporting social connectedness. This also involves improving perceptions of public safety and amenity.

Rural and remote communities, and Indigenous communities, are also affected by the impact on safety and amenity generated by alcohol, tobacco and other drug use.

Actions

- Make local communities and public places safer from alcohol-related violence and other incidents through stronger partnerships between health, law enforcement, liquor licensing, local government and planning and transport authorities.
- Continue to work within jurisdictions on transparent approaches on alcohol outlet density and takeaway hours and share examples of best practice.
- Consider further reforms to drink-driving laws and develop effective evidence-informed responses to driving under the influence of illegal and pharmaceutical drugs.
- Provide new supports for frontline workers (such as police, emergency medical service workers, paramedics, emergency department personnel and welfare workers) to manage poly-drug use and related aggressive behaviours in public places.
- Continue existing harm-reduction efforts including needle and syringe programs and safe disposal of used injecting equipment and improve access for disadvantaged populations.
- Improve community and workforce awareness of the health dangers of clandestine laboratories and the need for remediation of sites.
- Work with industry and consider regulation and other ways to reduce harms from emerging substances of concern, for example addressing the potential for energy drinks to exacerbate alcohol-related problems in public places.

Objective 2:

Reduce harms to families

The families of people using drugs—their parents, partners and children—often suffer significant impacts from their drug use. Support needs to be available to families, particularly with children, to help them manage the stresses they may be experiencing from a family member's drug use and help engage them in managing the individual's drug-related problem. Families also aid in recovery. Services for people with drug-related problems need to recognise the impact of drug use on families and help ensure they are provided or connected with the right support. This applies both to specialist alcohol and other drug treatment services and to policing, social welfare and other services that may be interacting with people with drug-related problems.

Alcohol is most commonly supplied to minors by parents and other family members. There are mixed community views on introducing teenagers to alcohol, with some support for introduction in a safe family environment. However, emerging health evidence highlights the importance of delaying introduction to alcohol as long as possible.

Drinking during pregnancy can have a significant impact on children in utero and cause a range of disorders known as foetal alcohol spectrum disorders (FASD). These include birth defects and developmental difficulties. FASD has been a particular issue in some Indigenous communities. Coordinated education and information campaigns and other clinical and community-led strategies are needed to help prevent FASD, and action is needed to improve the diagnosis and clinical management of affected children and to make available appropriate supports to those children and their families.

In relation to tobacco, families and communities have an ongoing responsibility to protect children from second-hand smoke and to help prevent children learning to smoke by example from parents and other respected elders. Efforts to reduce smoking among pregnant women, and prevention of the exposure of pregnant women and babies to second-hand smoke should be particular priorities.

Actions

- Enhance child and family sensitive practice in alcohol and other drug treatment services and build links and integrated approaches with community, family and child welfare services.
- Review existing national frameworks which address some of the causes of drug use, for example domestic violence strategies, and consider related actions that could be taken under the National Drug Strategy.
- Develop initiatives to reduce the secondary supply of alcohol to minors including through community education and information campaigns advising parents of health and social harms from alcohol and potential criminal justice outcomes.
- Continue preventive approaches to alcohol, tobacco and other drug use during pregnancy, including community education.
- Develop coordinated measures to prevent, diagnose and manage foetal alcohol spectrum disorders and make available appropriate supports to affected children and families.
- Consider the introduction of health warning labels, including pregnancy health warnings, on alcohol products.
- Introduce regulation and other appropriate measures to reduce the exposure of children to tobacco smoke in cars and other places.

Objective 3:

Reduce harms to individuals

Some of the major challenges in responding to the harms to individuals caused by drug use and poly-drug use lie in making individuals aware of the harms to their health, safety and wellbeing from drug use, motivating them to seek and engage with treatment, and connecting them with appropriate treatment and other support services.

For many individuals this requires a change of perspective and self-acknowledgement of a drug-related problem before there is a willingness to enter treatment.

Injecting drug use carries additional risks and harms for the individual, requiring particularly focused approaches. Disadvantaged populations may also be at greater risk of harm from drug use.

Actions

- Strengthen evidence-based drug education initiatives to ensure they are appropriately targeted in terms of patterns of drug use through the life span and mode of delivery.
- Enhance treatment and associated service systems across settings to provide help at all stages of drug use, particularly for disadvantaged populations.
- Raise awareness of the harmful impacts of drug use in the workplace including through resources that promote improved practice and better links to treatment and other support.
- Develop and implement internet-based approaches to target individuals with problematic drug use who do not think they have a problem and encourage them into treatment and/or other service supports.
- Continue successful illicit drug diversion programs and extend their application to alcohol and other substances where indicated.
- Sustain efforts to prevent drug overdose and other harms through continuing substitution therapies, withdrawal treatment and other pharmacotherapies.
- Support peer-based approaches to reducing harms associated with an individual's drug use.
- Continue support for needle and syringe programs and encourage safe injecting practices.

3. Supporting approaches

The three pillars of the *National Drug Strategy 2010–2015* are underpinned by the development of a qualified workforce, maintaining and improving the evidence base, monitoring performance and enhancing governance.

Workforce

Commitment to workforce development
An appropriately skilled and qualified workforce is critical to achieving and sustaining effective responses to drug use.

The *National Drug Strategy 2010–2015* is committed to addressing a range of factors affecting the ability of the workforce to function with maximum effectiveness.

Who is the workforce?
The Australian alcohol and other drug workforce involved in the prevention and minimisation of drug misuse is highly varied, spanning a diverse range of employment sectors, industries and communities.

Exposure to people who misuse drugs and the consequences of their drug use varies across the workforce. Each of the following groups has unique and specific workforce needs that require comprehensive and systematic development:

- **Alcohol and other drug workers** in treatment, prevention, health promotion and community services comprise multiple occupations that are engaged in a wide variety of roles. These include alcohol and other drugs specialists, generalist workers, needle and syringe program workers and peer workers. Appropriately qualified, skilled and experienced alcohol and other drug workers also have a role in partnering with and advising other services who encounter people who use drugs.
- In their day-to-day operations, the law enforcement workforce, including **police, customs and border protection officers and corrections officers** regularly engage with the consequences of drug misuse.
- **Emergency medical services, paramedics, emergency department personnel, police and corrections officers** are faced daily with the traumatic effects of drug misuse.
- The **mental health workforce** has a close professional affiliation with the alcohol and other drug workforce, often sharing an overlapping client base.
- The **health and medical workforce**, including general practitioners and other primary healthcare workers and hospital workers, has regular exposure to alcohol, tobacco and other drug use and its consequences and responsibility for treating a range of associated medical problems and the appropriate prescribing of pharmaceuticals.
- **Indigenous health and law enforcement workers** are at the front line for delivery of services related to preventing and minimising drug use and associated problems in their communities.
- Specialist groups such as **culturally and linguistically diverse health workers and those working in other areas such as child protection and disability services** deal with a range of complex community needs.
- **Pharmacists** and the pharmacy workforce often have close contact with drug use through their commitment to the provision of opioid substitution treatment and needle and syringe programs. They also have an important role in precursor control, preventing pharmaceutical misuse and providing nicotine replacement therapies.
- The **education sector** plays a key role in prevention and early intervention of drug use.

- Community and support services, including workers from the **welfare, child protection, homelessness, unemployment, income support and youth sectors** all regularly encounter people experiencing the harms associated with drug use.
- **Hospitality workers** encounter the harms associated with alcohol, tobacco and other drug use on a day-to-day basis.

What challenges face the workforce?
The following have been identified as workforce development priorities for the strategy:

- Promote minimum qualifications of alcohol and other drugs specialist service workers and accreditation of services. Work has commenced in a number of jurisdictions to examine ways to ensure minimum qualifications for workers. This will include feasible options for upskilling workers and accrediting services.
- Promote the inclusion of education on alcohol, tobacco and other drugs in the training of health professionals.
- Support the workforce in establishing and maintaining worker wellbeing.
- Build the capacity of the workforce to respond appropriately, provide support and refer people to relevant services.
- Build the capacity of the workforce to identify inappropriate use of substances and to act appropriately to prevent diversion.
- Build the capacity of the alcohol and other drugs specialist workforce to effectively respond to current and emerging alcohol, tobacco and other drug issues including as they relate to older populations, youth and the opportunities and challenges of new technologies.
- Build the capacity of the treatment workforce to strengthen outcomes from its work.
- Build the capacity of the general health workforce to identify drug-related problems and perform brief interventions.
- Use new technologies to make workforce development more accessible.
- Enhance workers' research literacy by facilitating research partnerships between clinicians, policy makers and researchers.
- Address specific issues of workforce supply such as attracting and retaining alcohol and other drugs specialist workers, the impact of the ageing workforce and the small Indigenous workforce.

A systematic approach to the workforce
The *National Drug Strategy 2010–2015* will continue to support the development of a qualified workforce. The Intergovernmental Committee on Drugs will establish a working group drawing in experts to develop a national workforce development strategy to help address these challenges with a particular focus on the alcohol and other drugs specialist workforce.

Evidence base

Commitment to evidence
An important aspect of Australia's approach to drug use has been the commitment to a comprehensive evidence base. Under the *National Drug Strategy 2010–2015* there is a continued commitment to **evidence-based** and **evidence-informed practice**. Evidence-based practice means using approaches which have proven to be effective. For example, the continuing provision of detoxification, pharmacological therapies including opioid substitution therapies and cognitive behavioural therapies for alcohol, tobacco and other drug treatment is based on an extensive body of evidence in Australia and internationally.

Evidence-informed practice involves integrating existing evidence with professional expertise to develop optimal approaches, including new or innovative approaches in a given situation. The *National Drug Strategy 2010–2015* includes a commitment to **innovation** and trialling new approaches. For example, the introduction of the Illicit Drug Diversion Initiative (IDDI) supported police-based diversion in early intervention and prevention programs before there was comprehensive evidence supporting this approach. The success of IDDI was a catalyst for its expansion into court-based diversion and treatment at correctional centres. IDDI demonstrates that where there is little evidence, leadership is needed to support innovation. Allowing room for the development of such creative approaches to be developed in the future will require new evidence to be collected so that the impact and quality of new interventions is well-understood.

Ongoing **evaluation** of approaches is also critical to the success of the *National Drug Strategy 2010–2015*. Evaluation ensures that existing programs and policies are appropriate, effective and efficient in the context of contemporary drug use patterns, trends and settings. For example, the long-standing needle and syringe programs have been regularly evaluated. The results have supported the expansion and evolution of the types of needle and syringe program services offered and demonstrated its ongoing efficacy, cost-effectiveness and public health value.

Generating evidence

Under the National Drug Strategy a strong evidence base has been built over the past 25 years. This includes health, law enforcement, education, social and cultural evidence that contributes to the application of harm reduction, demand reduction and supply reduction. Three national drug research centres of excellence—the **National Drug and Alcohol Research Centre**, the **National Drug Research Institute** and the **National Centre for Education and Training on Addiction**—funded by the Australian Government under the National Drug Strategy provide and disseminate high-quality research that contributes to evidence-informed practice by health, law enforcement and education services. The research centres undertake work in a number of key priority areas including treatment, prevention, drug use and young people, workforce, Aboriginal and Torres Strait Islander peoples, and emerging trends.

The National Drug Law Enforcement Research Fund is an important contributor to the evidence base for drug law enforcement practices at an operational level. Agencies that contribute to intelligence and research in this area include the Australian Institute of Criminology and the Australian Crime Commission. Most jurisdictions also have centres for criminal statistics and research that identify crime trends.

Other academic institutions contribute to the evidence base with support from the National Health and Medical Research Council, the Australian Research Council, universities and other sources.

It is also important that Australia learns from international evidence relevant to Australian conditions. The introduction of buprenorphine into the Australian treatment repertoire in 2005 was based on substantial international evidence, particularly from Europe, and then rigorously tested in Australia in a multi-centre trial. International sources of research will continue to contribute to the *National Drug Strategy 2010–2015*.

A systematic approach to research and data

The *National Drug Strategy 2010–2015* will continue to support the development of a strong evidence base including clinical, epidemiological, criminological and policy research. In areas where the evidence base requires further development, a systematic approach is necessary. In response to the recommendation of the evaluation of the *National Drug Strategy 2004–2009*, the Intergovernmental Committee on Drugs (IGCD) will establish a working group drawing in experts from the national research centres and other institutions to develop a national drug research and data strategy (see also Section 5 on performance measures). This will ensure a systematic approach to drug research by:

- identifying priority areas for new research and areas where evidence needs updating and/or validating
- coordinating research efforts
- facilitating the identification of emerging issues for research
- encouraging the testing and validation of new interventions
- guiding the dissemination of findings and assisting the translation of those findings into practical policies and programs.

Performance measures

Australia has a rich set of data sources relating to alcohol, tobacco and other drugs. This information contributes to a better understanding of drug markets, patterns of use, associated harms and patterns of treatment. Under the National Drug Strategy there is a strong commitment to improving data collections and using them to guide implementation. This section identifies three high-level performance measures that will help gauge progress and guide implementation of the *National Drug Strategy 2010–2015*. These measures build on existing performance measures identified in other national agreements such as those identified in the National Partnership Agreement on Preventive Health, the National Healthcare Agreements, the Fourth National Mental Health Plan and *The Road Home: A National Approach to Reducing Homelessness*.

The performance measures are high-level for several reasons:

- Data are not always comprehensive enough to provide robust national measures of activity and progress.
- It is not possible to directly match the objectives of the strategy, or each drug type, to a performance measure.
- The proposed measures use existing published data sources to help ensure continuity of approach.

The performance measures are intended to provide a broad indication of progress against the three pillars of the *National Drug Strategy 2010–2015*.

Performance measure 1:

Indicators of drug use

Prevalence of drug use is a rough proxy measure of progress in demand reduction. Under the National Drug Strategy measures of prevalence vary according to drug type.

- For illegal drugs—prevalence is defined as the proportion of people who used an illegal drug in the previous 12 months, for each drug type.
- For tobacco—prevalence is defined as the proportion of people who smoke daily.
- For alcohol—prevalence is defined as the proportion of people who consume alcohol at risky levels.
- For all drug types—average age of initiation of drug use is also an important indicator.

Progress against this measure will be indicated by falls in prevalence and increases in ages of initiation. However, there is not necessarily a straightforward relationship between prevalence data and success or otherwise in demand-reduction strategies. Fluctuations in prevalence may be unrelated to underlying demand. For example, increases in the supply of a particular illegal drug may result in increases in opportunistic use. Prevalence data should be considered alongside other performance measures, and complemented by qualitative and quantitative research and contextual information to provide a broad interpretation of the data.

It is also useful to examine prevalence within sub-populations to help guide policy and program responses. For example, in 2007 general population data showed recent use of ecstasy as relatively stable, but closer examination showed a significant increase in use amongst 14–19-year-old females.

Patterns of drug use should also be considered. There may be instances where the general population prevalence of a drug may be decreasing, but among regular users the frequency of use, and potentially associated harms, may be increasing.

Existing published data that will inform this performance measure includes: the National Drug Strategy Household Survey and the National Health Survey for the general population; the Australian Secondary Students Alcohol and other Drug Survey for youth-specific prevalence measures; and the National Aboriginal and Torres Strait Islander Health Survey for this population group. Jurisdictions will also use major state-based population health surveys.

Over time, consideration should also be given to including treatment data in this measure, as the Alcohol and Other Drug Treatment Service National Minimum Dataset is reviewed and enhanced.

Performance measure 2:

Disruption of illegal drug supply

Measures which demonstrate progress in disrupting the production and supply of illegal drugs include:

- purity levels for illegal drugs by drug type
- the price for illegal drugs by drug type
- the number and scale of clandestine drug laboratories disrupted in Australia.

Progress against this measure will be indicated by falls in purity levels and increases in prices. However, there is not necessarily a straightforward relationship between price or purity and success or otherwise in supply-reduction strategies. For example, increases in price could reflect increases in demand as well as decreases in supply.

This measure needs to be interpreted alongside Performance measure 1 and in the context of both domestic and international law enforcement activities, such as the destruction of illicit drug and precursor stockpiles or the dismantling of criminal organisations or distribution/trafficking networks.

Data to support these measures can be sourced from existing data sets published by Australian and state and territory police agencies, the Australian Customs and Border Protection Service, the Australian Institute of Criminology and the Australian Crime Commission.

Performance measure 3:

Harm associated with drug use

Measures of harm associated with drug use include:

- the social costs of alcohol, tobacco and other drug use to the Australian community
- trends in drink-driving and drug-driving related deaths and injuries, and alcohol-related violent incidents
- perceptions of community safety regarding illegal drugs, and drunk and disorderly behaviour
- the prevalence and incidence rates of HIV and hepatitis C among injecting drug users
- trends in opioid overdose related ambulance call-outs and overdose mortality
- trends in alcohol-related emergency admissions and hospital separations.

Decreases and falling trends against all these measures (except community safety perceptions, which the strategy seeks to improve) would demonstrate progress against this measure.

Careful interpretation is needed. For example, a statistical increase in arrests for drink or drug-driving may be related to intensification of police operations rather than an actual increase in these behaviours.

Comprehensive national data are not available on all of these measures. Existing sources include state and territory policing data, and Australian Bureau of Statistics and Australian Institute of Health and Welfare reports. National surveys such as the National Survey of Community Satisfaction with Policing, as well as commissioned research on social costs of drug use will help inform these measures.

The National Research and Data Working Group will prepare an annual report on data against these measures to be included in the annual report of the Intergovernmental Committee on Drugs. This group will examine improving the quality of the data sources that inform these measures.

Governance

The governance structure to support the *National Drug Strategy 2010–2015* is detailed in Figure 2. This structure represents the successful partnership between law enforcement and health and strengthens the engagement of other stakeholders.

Continued partnership between health and law enforcement portfolios

The Ministerial Council on Drug Strategy (MCDS) was established at a Special Premiers' Conference on 2 April 1985. It was agreed that the MCDS would coordinate and direct the then National Campaign Against Drug Abuse (1985–92) and have authority to deal with all drug-related matters. It was also agreed that the National Drug Strategy would take a balanced approach on demand and supply and on minimising the harms drugs cause.

The establishment of the Council as the auspicing group for the strategy set up a unique and new partnership between law enforcement, health and education which has enabled great strides to be taken in demand, supply and harm reduction through integrated approaches. This partnership approach will be maintained under the *National Drug Strategy 2010–2015*.

On 13 February 2011, the Council of Australian Governments (COAG) approved a comprehensive reform plan for a new system of ministerial councils. These changes will see a fundamental shift towards a council system focused on strategic national priorities and new ways for COAG and its councils to identify and address issues of national significance. The new arrangements for COAG and its councils will be in place from 1 July 2011. Standing councils on health and on police and emergency management will progress priority issues relevant to their portfolio areas. The MCDS met for the last time on 25 February 2011 and agreed that the Intergovernmental Committee on Drugs would identify strategic issues for discussion that could be addressed at annual informal meetings of interested health, police, attorneys-general, education and other relevant ministers.

Intergovernmental Committee on Drugs

The **Intergovernmental Committee on Drugs** (IGCD) will manage the ongoing work of the National Drug Strategy. The committee is a Commonwealth, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction and in New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations.

The committee provides policy advice to relevant ministers on drug-related matters, and is responsible for implementing policies and programs under the National Drug Strategy framework.

The IGCD will prepare an annual report on its activities that will be provided to health, police, attorneys-general, education and other relevant ministers.

Members of the IGCD form the health officials and law enforcement officials subcommittees, which facilitate a focused approach on relevant health and law enforcement issues.

IGCD standing committees and working groups

The IGCD will be supported by four **standing committees**. These will focus on alcohol, tobacco, illicit drugs and pharmaceutical drug misuse. The standing committees will provide ongoing guidance and expertise to the IGCD on issues relevant to their respective drug types, and will lead the updating or development of their respective sub-strategies.

Time-limited working groups will also be established during the life of the strategy. The working groups will be given discrete, time-limited tasks which align with priority areas identified in the strategy. The three immediate priority areas are the development of the Aboriginal and Torres Strait Islander Peoples Drug Strategy, a national drug research and data strategy, and a national workforce development strategy.

The working group structure will allow for additional groups to be established as new priorities are identified.

The IGCD will invite relevant representatives of intergovernmental councils, government agencies, non-government organisations, the research sector, peak organisations, consumers, carers and industry to participate in these committees and groups.

Stakeholder engagement
The IGCD will convene an **annual stakeholder forum** to discuss issues related to drug policy. The forum will engage a range of drug and alcohol experts and a broader selection of stakeholders including consumers, carers, consumer representative groups, peak bodies, non-government organisations and industry.

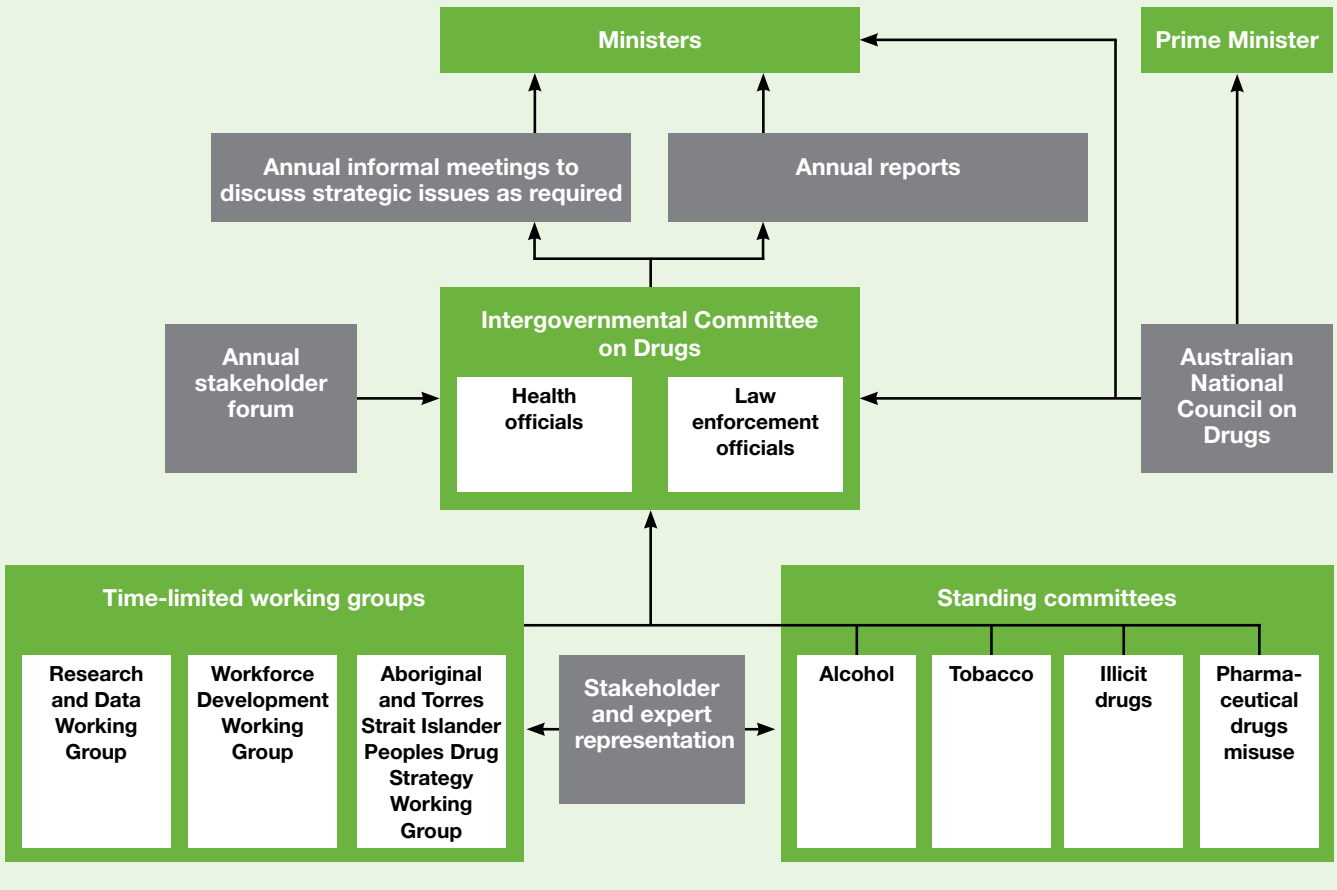
Outcomes from the forum will inform discussion at the annual IGCD strategic workshop.

Australian National Council on Drugs
The **Australian National Council on Drugs** (ANCD) will continue to provide ministers and senior government officials with independent, expert advice on matters connected with legal and illegal drugs. The ANCD is also tasked to facilitate enhanced partnership and communication between government and the community in the development and implementation of policies and programs to redress drug-related harms.

Members of the ANCD are appointed by the Prime Minister. They include people with a wide range of experience and expertise in various aspects of drug policy such as treatment, rehabilitation, education, family counselling, law enforcement, research, and work at the coalface in community organisations.

The ANCD will develop a work plan and report annually to the Prime Minister. It will also provide reports to relevant ministers and the Intergovernmental Committee on Drugs.

Figure 2: Governance structure to support the *National Drug Strategy 2010–2015*



Appendix A

Other national frameworks relevant to the *National Drug Strategy 2010–2015*

- The Sixth National HIV Strategy 2010–2013
- The First National Hepatitis B Strategy 2010–2013
- The Second National Sexually Transmissible Infections Strategy 2010–2013
- The Third National Hepatitis C Virus Strategy 2010–2013
- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy
- National Framework for Protecting Australia's Children 2009–2020
- *Investing in the Early Years*—A National Early Childhood Development Strategy
- National Mental Health Strategy
- National Suicide Prevention Strategy
- Organised Crime Strategic Framework

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All information in this publication is correct as of March 2011

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